Matters arising

Why do patients default from follow up at a genitourinary clinic?

The recent article by Ross *et al*[1] demonstrated several variables of significance relating to whether or not patients keep review appointments in genitourinary medicine clinics. That study was done in a large teaching hospital in Edinburgh serving the whole of SE Scotland. As a comparison, we repeated the study in Fife (a semi-rural ex-mining area of 350 000 population). The methodology for the Fife study was as described in Ross's paper.[1] During November 1995 129 patients with a review appointment defaulted, and were compared with a control population of 115 randomly selected from the 229 review patients seen during the same period. The default rate of 36% was much higher than the Edinburgh experience (15%). Variables included in the initial analysis and those found to be relevant in the final model following forward conditional analysis are shown in the table.

Review appointments were more likely to be kept if symptoms were present at the previous attendance, whereas age less than 20 years and previous attendance more than two weeks previously were significantly associated with non-attendance. The overall default rate was more than twice that in Edinburgh, and might be at least partly explained by a different review policy: in Fife patients are offered an appointment for routine 3 month syphilis serology, and those with warts are offered a 3 month appointment once the warts have resolved to check for reappearance.

In the Edinburgh study, being seen by a Health Advisor at a previous attendance was associated with being more likely to keep the next appointment. In Fife this variable did not reach statistical significance. However, compared with the Edinburgh experience of less than half, over three-quarters of patients in Fife were seen by the Health Advisor. Timing of appointment was also relevant in the Edinburgh study where review patients had tended to be given afternoon appointments, but this was not of significance in the Fife study where the appointment system allows both new and return patients to be seen in both morning and afternoon clinics. Living in or around Edinburgh was associated with less likelihood of defaulting, and it was surprising, therefore, that in a semi-rural area where the public transport is often infrequent, residing outwith the clinic town was not a factor predictive of defaulting in Fife.

The overall high default rate in genitourinary medicine clinics in Fife is cause for concern as it results in ineffective use of trained staff and makes rational planning of resources impossible. A change in review policy for specific groups, and targeting the younger patients and those without symptoms about the importance of keeping review appointments are all measures which might help

Multivariate logistic regression analysis relating risk of defaulting with various factors

Variable		*No defaulting*	*No. attending*	*OR of defaulting*	*95% CI*
Age	20 or more	90	99	1·00	
	Under 20 years	39	16	1·70	1·08–2·66
Time of appointment	Morning	70	65	1·00	
	Afternoon	59	50	1·25	NS
Day of appointment	Monday	30	22	1·00	
	Tuesday	13	13	0·67	NS
	Wednesday	24	25	0·94	NS
	Thursday	25	21	1·74	NS
	Friday	37	34	0·86	NS
Last seen by doctor of same sex	No	50	45	1·00	
	Yes	79	70	1·02	NS
Employed	No	56	35	1·00	
	Yes	73	80	0·98	NS
Parity	Women without children	48	37	1·00	
	Women with children	27	17	0·33	NS
Referral source	GP	55	64	1·00	
	Self	34	30	0·95	NS
	Contact	22	12	1·10	NS
	Other	18	9	1·11	NS
Seen by Health Advisor	No	34	20	1·00	
	Yes	95	95	0·73	0·49–1·08
Sex	Male	55	61	1·00	
	Female	74	54	12·16	NS
Diagnosis	Warts	53	67	1·00	
	Gonorrhoea/NSU/chlamydia	44	28	1·10	NS
	Other	32	20	1·06	NS
Symptoms present at last visit	No	81	33	1·00	
	Yes	48	82	0·63	0·44–0·90
Time since last visit	2 weeks or less	47	84	1·00	
	Greater than 2 weeks	82	31	2·00	1·44–2·77
Area of residence	Outwith clinic town	82	67	1·00	
	Clinic town	47	48	0·91	NS
Clinic	Dunfermline (peripheral)	35	32	1·00	
	Kirkcaldy (main)	94	83	0·99	NS
Weather	Dry/mixed	110	96	1·00	
	Raining	19	19	0·88	NS
No. previous attendances	3 or more	47	40	1·00	
	2 or less	82	75	0·97	NS
Forward Conditional Analysis					
Age less than 20 years		39	16	1·49	1·05–2·13
Symptoms present at last attendance		48	82	0·58	0·43–0·77
Previous attendance more than 2 weeks ago		82	31	1·86	1·39–2·48

improve the attendance rate and which should be considered to maximise the use of current resources.

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Prevention and management of tuberculosis in HIV positive patients

Brook and Miller have raised many important issues in their review of tuberculosis and HIV.[1] We agree with most of what they have said; however, we differ on two points. Their assertion that "there are no published data on the interpretation of tuberculin testing in BCG vaccinated HIV-positive patients" is incorrect.[2 3]

Secondly, to isolate all patients with fever and weight loss (which in the UK will be most commonly due to *Pneumocystis carinii* pneumonia) in negative pressure rooms because of the fear of radiological and sputum-negative, broncho-alveolar lavage-positive TB, will require enormous financial investment in HIV units. It may be more practical to treat such patients outside units dedicated to patients with immuno-suppression pending the exclusion of tuberculosis as the cause of their cough and fever.

We strongly endorse their view that tuberculosis in this group of patients is underreported. Compliance with the regulations on the notification of tuberculosis will greatly improve the management of patients with this infection who are a challenging public health problem.

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2 Higgins SP, Bradbeer CS, Bateman NT. Tine testing in HIV positive patients. *Thorax* 1993;48:831–4.
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